



# **BEACON HEALTH SYSTEM**

## **IMPLEMENTATION STRATEGY PLAN**

**2025-2027**

615 N. Michigan St.  
South Bend, IN 46601

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# Introduction

## Executive Summary

Beacon Health System completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the four hospital boards in the fall of 2024. Beacon Health System performed the CHNA in adherence with federal requirements for not-for-profit hospitals set forth in the Affordable Care Act (ACA) and by the Internal Revenue Service (IRS). The assessment included a comprehensive review of secondary data on health outcomes and community health status, along with primary data collection. This involved input from community members and organizations through surveys, stakeholder interviews, focus groups, and an analysis of Beacon Health's service utilization data.

The complete CHNA report is available electronically at <https://impact.beaconhealthsystem.org/chna/>.

## Health Needs of the Community

Beacon Health System's service area is identified as Elkhart County, Marshall County, St. Joseph County of Indiana and St. Joseph County of Michigan. A modified Delphi Technique was used to complete the Needs Prioritization. Originally developed by RAND in the 1950s, the Delphi Technique uses a multi-stage iterate qualitative and quantitative process for decision making consensus. The needs prioritization was conducted in four stages over the course of three weeks. The prioritization process included input through two rounds of surveys completed by Advisory Council members, Equity Champions, and Hospital Boards and qualitative meetings held by Equity Champions and Advisory Council members to discuss survey results, assess control, resources, and geography for each need, and calculate scores to identify top priorities. A final survey confirmed the most critical needs and broader categories.

The CHNA process identified significant health needs for these communities, with one priority designated to be addressed system wide: Access to Providers. A total of 49 community needs were identified from the primary and secondary quantitative and qualitative research and categorized into 7 categories:

1. Access to providers
2. Access to care services
3. Improving health outcomes
4. Access to behavioral health services
5. Basic needs
6. Community engagement
7. Older adult services

Beacon Health System leverages its resources and partnerships across the counties it serves to create a meaningful, large-scale community impact. To enhance access to providers, Beacon Health is committed to developing, supporting, and evaluating initiatives that drive measurable improvements. This implementation strategy outlines the key community health needs the hospitals and health system will address in collaboration with partner organizations, aligning with our mission to be the trusted health partner for our communities. Beacon Health may modify this strategy as needed to adapt to changing circumstances.

## About Beacon Health

### Mission

*We deliver outstanding care, inspire health and connect with heart.*

Headquartered in South Bend, Indiana, with 20 specialized partners and nearly 8,000 associates throughout the region, Beacon connects you with the care you and your family need to be your very best. That takes expertise. We are the regional leader in comprehensive, integrated services — from childbirth and pediatrics to cancer, trauma, heart and vascular, stroke, orthopedics and sports medicine, surgery, mental health and so much more. Our passion is not only saving lives, but also making them better. That’s

why we created a health care system that is here for people no matter where they are ... in their physical location or in their wellness journey. We have locations across the region that provide a wide variety of expert, nationally recognized services available only at Beacon. This ensures everyone is connected with the care they need so they can live their best lives, right here.



### Memorial Hospital of South Bend

Memorial Hospital includes 434 staffed beds with more than 600 physicians on staff representing more than 35 medical specialties. Memorial Hospital has been recognized numerous times for its quality patient care, including an INSpire award from the Indiana Hospital Association as a

Hospital of Distinction and certification as a Perinatal Center by the Indiana Department of Health. Beacon Children’s Hospital sits within Memorial Hospital of South Bend. Beacon Children’s Hospital is the region’s only comprehensive children’s hospital. We welcome and treat children from 31 referring hospitals across 15 counties throughout Michigan and Indiana. We have all the expertise of a large health system and deliver the warm and friendly pediatric care you’d expect from a community hospital.



## Elkhart General Hospital

For over 100 years, the highly skilled professionals of Elkhart General Hospital have been providing comprehensive medical care to Elkhart and surrounding communities. We are a patient-first health care organization whose ongoing mission is to help create healthier communities throughout

Michiana. We carry out that mission one patient at a time. One family at a time. We carry out that mission by always putting our patients' needs first.

Our main hospital campus is situated in the City of Elkhart beside the beautiful St. Joseph River. Our full-service, 357-licensed-bed main hospital is comprised of over 300 physicians representing more than 30 medical specialties, and nearly 2,000 employees serve in nursing, technical, administrative, and support capacities.



## Memorial Epworth Center

Memorial Epworth Center operates a 50-bed psychiatric hospital for adults and adolescents ages 13 and above. Services provided include short-term stabilization and support to people who are experiencing a psychiatric

emergency that cannot be managed in an outpatient setting.

Prior to discharge, patients and staff work together to create a safety plan and comprehensive discharge plan, which includes linking patients to other, less intensive services to help prevent future emergencies.



## Community Hospital of Bremen

Our 24-bed critical access hospital employs 170 associates and serves Bremen, Indiana, and the surrounding communities. As part of Beacon Health System, patients have access to providers, resources and services from across the entire health system.

The hospital provides the community with: Emergency Department; diagnostic imaging and lab; radiology, including MRI, CT and ultrasound; surgery; obstetrics; sleep lab; mammography; physical and occupational therapy; occupational health; swing bed services; and infusion therapy.



## Three Rivers Health Hospital

For more than a century, Three Rivers Health Hospital has served St. Joseph, Kalamazoo and surrounding southern Michigan communities. Three Rivers Health Hospital employs about 550 associates in the hospital and 16 clinics. We offer a variety of inpatient and outpatient services, including emergency care, inpatient rehabilitation,

orthopedics and women’s health. Beacon Health & Fitness Three Rivers is a fitness center at the hospital’s campus.

I-Med, Three Rivers Health’s urgent care, provides a wide range of convenient and timely health care services. These services are available to individuals and local businesses with no appointment necessary. Our testing and diagnostic capabilities keep our community healthy. From allergies to X-rays, our expert team specializes in the prompt treatment of common illnesses and injuries.

## About Implementation Strategy Plans

In alignment with the Affordable Care Act (ACA), the Internal Revenue Service (IRS) and applicable federal requirements for not-for-profit hospitals, Beacon Health System completed a comprehensive regional Community Health Needs Assessment (CHNA) for its four hospitals. The CHNA was adopted by each of the hospital boards in Fall 2024.

In addition to the CHNA, not-for-profit hospitals are also required to complete an Implementation Strategy Plan (ISP). The intent of the ISP is to respond to the community needs with an implementation plan that can be effectively executed leveraging hospital resources as well as community partners. This ISP was also adopted by each of the hospital boards in Spring 2025.

The ISP is an iterative plan and should be modified as internal and external factors change, including emerging needs, availability of resources, partnerships and policies. An ISP should build on and leverage prior success while simultaneously adjusting strategies and actions as obstacles are encountered.

The following Beacon Health ISP is a working document and may be updated over the course of the next three years as internal and external factors change. A revised version of the plan may be added to the Beacon Health website to replace the original version. Each version will notate any changes made to the plan.

## Definitions

When a hospital or health system develops an ISP, it tracks both outputs and outcomes to support the monitoring and evaluation of its success. Both output measures and outcome measures are used to assess the effectiveness, but they serve different purposes.

Aspect	Output Measures	Outcome Measures
<b>Definition</b>	The immediate results or deliverables of an activity.	The broader impact or benefits resulting from an activity.
<b>Focus</b>	Quantity of work done.	Quality of change or impact.
<b>Timeframe</b>	Short-term and easier to measure.	Longer-term and harder to measure.
<b>Example</b>	# of patients seen by a doctor.	Reduction in disease rates or improved patient health.
<b>Measurement Type</b>	Typically quantitative (count, frequency, percentage).	Can be qualitative or quantitative (surveys, observations, statistics).

In response to the needs identified from the community served, we will define vulnerable populations as individuals at risk of experiencing poor health outcomes due to social, economic, or environmental factors. Factors such as low income, chronic diseases, uninsured, underinsured, homelessness, substance misuse, rural areas, and inner cities throughout this document.

## Methodology

The Implementation Strategy Plan (ISP) was developed with the insights and input from the Beacon Health Advisory Council, an Internal Advisory Council, key Beacon Health System and community partner leaders, and Board Members from each of the four hospitals. Individuals either participated in a short survey or a short telephone or Zoom interview. The interviews took place in November 2024 with 16 individuals.

Additionally, a literature review of best practices and case studies was conducted to identify potential initiatives or programs that could be implemented at Beacon Health to improve the overall access to providers in the four-county service area.

### About the Health Advisory Council

An Advisory Council was established in November 2023 of community partners that serve community residents in Beacon Health System's service area. The Advisory Council and other community partners received MAPP 2.0 training in the March 2024 over the course of two days. With this training, Advisory Council members provided oversight and participation in the Community Health Needs Assessment (CHNA) and Implementation Strategy Plan. We also brought together an internal Advisory Council with experts across the system to provide input and guidance to the ISP. The internal Advisory Council met three times in December 2024 and January 2025. A list of Advisory Council organizations and internal Advisory Council members are located in Appendix C.



## Priority Area: Access to Providers

During the Community Health Needs Assessment process, a total of 49 community needs were identified from the primary and secondary quantitative and qualitative data. A multi-stage needs prioritization process resulted in **Access to Providers** as the top community priority area for the four-county Beacon Health service area.

Access to Providers encompasses the following key elements:

- Primary care
- Specialty care
- Community health worker models
- Cultural competency
- Community mistrust

The table to the right depicts the 10 specific needs that fell under the Access to Providers category for the Beacon Health System.

While other needs were identified in the Community Health Needs Assessment, Access to Providers was identified as the top need in the community as access to providers is often the bottleneck to increasing access to care services and improving health outcomes in the community. The Beacon Health System service area, especially the more rural counties, are struggling with provider shortages and transportation challenges which limit the access to care for community residents. By addressing access to providers, access to care services and other needs identified during the community health needs assessment process should also improve. Appendix D provides additional information from the CHNA supporting the need to address access to providers across our service area.

- Primary care provider shortage
- Endocrinology
- OBGYN, including childbirth at hospitals
- Pediatricians
- Rheumatology
- Neurology
- Podiatry
- Community health workers or peer support specialist
- Cultural competency of providers
- Community mistrust of providers in their communities

# Strategy Plan

Goal: Improve access to providers across Beacon Health’s service area.

## Strategy #1

Expand access to non-clinical community health services by integrating community health workers, peer support specialists, peer recovery coaches, and health navigators to address social drivers of health and improve care coordination.

Tactics	Output Metrics	Baseline
1.1. Engage with community organizations and providers using community health workers or peer support specialists to explore collaboration and identify best practices for similar programs.	# of organizations providing support for non-clinical community health services.  # of best practices implemented into programming across 4 counties.	Establish in yr 1
1.2 Establish a referral pathway for hospital EDs and primary care practices to connect patients with non-clinical community health services.	Increase # of referrals from hospitals and/or clinical practices to non-clinical services.  % of patients screened for social needs.  % of social needs followed up on from non-clinical services.	Establish in yr 1
1.3 Collaborate with community partners to develop Mobile Integrated Health models that expand healthcare access, particularly in rural areas with limited OBGYN services.	Increase # of patients served through the Mobile Integrated Health model.  % increase in prenatal and postpartum care access in rural areas.	Establish in yr 1  Establish in yr 1
1.4 Enhance the Michiana Community Health Coalition website's resource guide by creating county-specific guides and a Spanish version listing organizations that offer services in Spanish.	Increase # of website visits of resource guides.  Completion and publication of a Spanish resource guide.  % of county-specific guides completed.	302 visits for 51 visitors (Q4 2024)  N/A  25%

### Outcome Metrics for Strategy 1

Increase % of social needs met for community residents and Beacon patients.

Decrease hospital readmission rates for vulnerable populations.

Decrease ED visits for vulnerable populations.

Improvement in maternal and infant health outcomes (high blood pressure, pre-eclampsia, maternal mental health) in historically underserved populations.

## Strategy #2

Enhance communication and care coordination between providers within and outside the Beacon Health System by implementing standardized referral processes, secure data-sharing platforms, and cross-organizational collaboration efforts.

Tactics	Output Metrics	Baseline
2.1. Conduct an audit with internal and external providers to identify communication challenges across different data systems.	% of internal and external providers who participate in the audit.  Implementation rate of corrective actions identified to improve data system communication.	Establish in yr 1
2.2 Train providers and staff on effectively using IHIE and MiHIN to access patient data from external providers.	Increase the # of providers utilizing IHIE and MiHIN.  % of providers trained in using IHIE and MiHIN.	Establish in yr 1
2.3 Beacon leadership engage practices not providing data and information to IHIE or MiHIN to increase participation.	Increase percent of practices participating with IHIE and MiHIN.	Establish in yr 1
2.4 Enhance the referral pathway for non-clinical community health services through ensuring timely and accurate transfer of patient information between providers.	Complete level zero milestone for data sharing.	N/A

### Outcome Metric for Strategy 2

Decrease % of CHNA respondents who reported the community needing to improve coordination of patient care between service providers.

**BASELINE: 45.2%**

## Strategy #3

Improve healthcare access for community residents by strengthening partnerships with community organizations and increasing access to providers through targeted recruitment and development efforts and expand services to reach underserved populations while enhancing healthcare navigation.

Tactics	Output Metrics	Baseline
3.1 Beacon Medical Group and hospitals draft and follow a three-year recruitment plan for primary and specialty care with specified targets.	Annual review of BHS three-year strategy recruitment plan.	N/A
3.2 Increase patients enrolled in patient portal to access their health information, schedule appointments, and communicate with their providers.	Increase % of BHS unique patients enrolled in patient portal.	51%
3.3 Improve the discharge process to ensure patients have follow-up appointments scheduled with their providers before being discharged.	Increase # of patients scheduled for follow up appointment at discharge in ED. Reduce the unattributed patient rate.	Establish in yr 1 28%
3.4 Enhance options for community residents with transportation barriers.	# of patients served through the Mobile Mom Unit. # of trainings provided on telehealth. # of transportation incentives distributed to those with identified with transportation needs.	Establish in yr 1
3.5 Increase access to providers or services in the patient's preferred language (ex. Spanish, ASL, etc).	Increase # of staff trained on usage of the language line. Increase usage of language line.	Establish in yr 1
3.6 Collaborate with FQHCs to enhance healthcare access for community members who are uninsured, underinsured, or face social drivers of health barriers.	# of FQHC partnerships established. Reduction in wait times for appointments at FQHCs. % of patients screened for social needs at FQHCs. % of social needs followed up on. Increase the # of MHS patients who are non-compliant with their wellness visits receive a referral to an FQHC.	Establish in yr 1
3.7 Increase opportunities for health system workforce development.	Increase participation in the pathway program. Increase # of participation in the health system workforce programs from schools in target Zip Codes. Increase participation in hospital medical education program at MHSB and EGH.	Establish in yr 1 Establish in yr 1 16

### Outcome Metrics for Strategy 3

Increase % of social needs met for community residents and Beacon patients.

Decrease hospital readmission rates for vulnerable populations.

Decrease in individuals using the ED for non-emergency conditions.

## Strategy # 4

Build community trust by promoting patient-centered care in each county.

Tactics	Output Metrics	Baseline
4.1. Conduct trainings, such as the US Department of Health & Human Services' Think Culture Health training, the HEAL program, and how to be a trusted person, with all current and future providers.	# of providers and staff who received trainings. Increase # of providers who report understanding how to be a trusted individual in their communities.	Establish in yr 1
4.2 Utilize Community Health Workers (CHWs) to build trust in vulnerable populations.	Increase # of CHW-led community outreach sessions conducted in target populations. Increase # of individuals reached by CHWs through home visits, educational sessions, and/or healthcare navigation support.	Establish in yr 1
4.3 Enhance Beacon's Joint Commission Dyad team, which includes case management, quality, population health, and community impact, to address SDOH needs in priority populations (chronic health and maternal health).	Increase # of Dyad strategic meetings held for actionable SDOH discussions.	2
4.4 Provide education on medications for Opioid Use Disorder (MOUD) for emergency department physicians and primary care providers (PCP) to become more familiar with and to provide MOUD.	Increase # of providers attending Grand Round sessions on MOUD. Increase # of PCP providers participating in MOUD education trainings.	Establish in yr 1
4.5 Develop and implement an outreach plan to encourage provider participation in community health events.	Increase # of providers engaging in community events.	Establish in yr 1

### Outcome Metrics for Strategy 4

Decrease percentage of CHNA respondents who reported they do not trust their providers or staff.

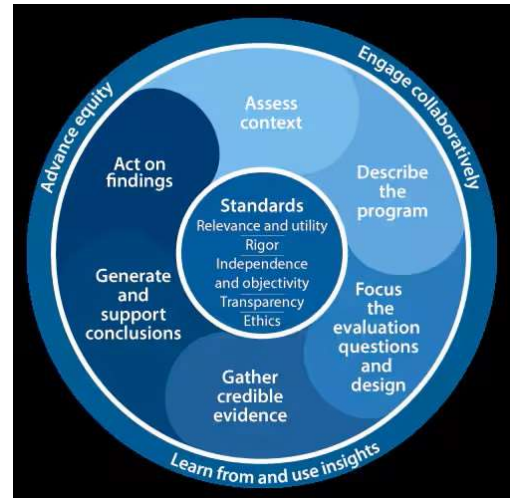
**BASELINE: 16.3%**

# Evaluation

Evaluation of any Implementation Strategy Plan is just as critical as the implementation of strategies, programs, and initiatives. To measure progress of goals, Beacon Health System will utilize the Center for Disease Control and Prevention (CDC) Program Evaluation Framework (2024). The three foundational principles of the Framework are engaged collaboratively, advance equity, and learn from and use insights.

The Framework includes six steps to complete a successful evaluation:

1. Assess the context
2. Describe the program
3. Focus the evaluation question and design
4. Gather credible evidence
5. Generate and support conclusions
6. Act on findings



Beacon Health will evaluate the progress on each goal on an annual basis. Starting at Year 0, Beacon Health will determine the baseline for each goal. Each year after Year 0, the progress will be measured against the baseline. Whenever possible, Beacon Health will use local, state, and national benchmarks, such as Healthy People 2030 or County Health Rankings, as additional benchmarks to measure against each year.

The evaluation of the ISP strategies should include both quantitative and qualitative assessments as not every goal can be successfully measured quantitatively. It is important to learn qualitative findings, such as the human stories to each strategy. Each strategy and supporting tactics include both outputs and outcomes



# Appendix

**Appendix A:** Literature Review

**Appendix B:** Implementation Plan Interview Guide

**Appendix C:** CHNA Health Advisory Council and ISP Advisory Council

**Appendix D:** Access to Providers Data Overview



## Appendix A: Literature Review

Ensuring access to healthcare providers, especially in specialty fields, is essential to meet the needs of Beacon Health's diverse and underserved communities. Data from Beacon Health's 2023 Access to Providers Summary reveals significant shortages in primary care, mental health, and specialty providers across counties, particularly in Marshall County and St. Joseph County (MI). Even more urban areas, like St. Joseph County (IN), struggle to maintain adequate provider-to-patient ratios, underscoring the widespread nature of these challenges.

In rural counties, access barriers are compounded by higher rates of uninsured adults, limited work opportunities, and a lack of healthcare infrastructure. These issues often lead to delayed care, unmanaged chronic conditions, and greater strain on the few available providers. Addressing these shortages requires a multifaceted approach, incorporating recruitment and retention strategies, specialized workforce development, the expansion of community health workers (CHWs), and efforts to reduce financial barriers to care. This literature review examines these solutions, presenting evidence-based strategies to strengthen provider access and support Beacon Health's commitment to health equity.

### Recruitment and Retention of Providers in Rural Areas

Recruiting healthcare providers to rural and underserved areas is particularly challenging due to isolation, limited access to resources, and lower financial incentives compared to urban areas. Loan repayment programs, a common approach to attract providers, are beneficial but not sufficient for long-term retention. Renner et al. (2010) evaluated Colorado's loan repayment program and found that it successfully attracted providers to underserved areas. Renner and colleagues discovered that roughly 38% of providers who received loan repayment cited this incentive as influential in their decision to work in a rural area. Although noted that retention was more complex, influenced by factors such as community integration and job satisfaction beyond the financial incentives alone (Renner et al. 2010).

Studies by Lee and Nichols (2014) emphasize the importance of family-oriented recruitment processes that involve providers' families and highlight the lifestyle benefits unique to rural living. Their research indicates that fostering a strong sense of community and offering local support networks can improve retention rates among rural providers. Moore et al. (2024) further supports this by identifying community support, leadership opportunities, and recreational amenities as key factors that promote retention among healthcare providers in rural Idaho (Lee & Nichols, 2014; Moore et al., 2024). For Beacon Health, recruitment strategies that combine financial incentives, such as loan repayment, with community integration and family support programs may enhance provider retention in high-need areas.

## Specialty Provider Shortages and Workforce Development Programs

The lack of specialty providers, particularly in obstetrics/gynecology (OBGYN) and pediatrics, is a critical challenge for Beacon Health's rural counties. Provider data from 2023 reveals high OBGYN-to-patient ratios of up to 22,838:1 in Marshall County, illustrating the urgent need for targeted workforce development initiatives. Programs such as the Rural and Underserved Service Track (TRUST) offer a promising approach to addressing these shortages. TRUST is an interprofessional training program designed to prepare healthcare students for careers in rural areas by emphasizing cultural sensitivity, preventive care, and interprofessional collaboration. Klosko et al. (2023) demonstrate that TRUST's model successfully prepares providers for rural practice by fostering skills specific to the challenges of underserved populations (Klosko et al., 2023).

MacQueen et al. (2017) provides further evidence on the efficacy of rural-focused training programs, finding that providers with rural backgrounds or early exposure to rural practice environments are more likely to remain in rural settings. This suggests that establishing partnerships with educational institutions to develop rural-specialized tracks, especially for high-need specialties, could serve as a sustainable solution for Beacon Health to address provider shortages in some of the more rural counties (MacQueen et al., 2017).

## The Role of Community Health Workers (CHWs) in Addressing Provider Shortages

Community health workers (CHWs) play a vital role in expanding access to healthcare, particularly in areas with high patient-to-provider ratios. CHWs serve as intermediaries between healthcare providers and their communities, offering culturally relevant patient education, preventive care, and chronic disease management. Verhagen et al. (2014) found that CHWs are particularly effective at improving healthcare access and health behaviors among ethnic minorities, a role that is crucial in rural settings where cultural and language barriers may limit healthcare utilization (Verhagen et al., 2014).

In a diabetes management program studied by Otero-Sabogal et al. (2010), CHWs worked alongside primary care providers, resulting in improved patient glycemic control and overall self-management. This model relieved pressure on primary care providers and improved patient satisfaction, demonstrating CHWs' value in supporting chronic disease management within underserved communities (Otero-Sabogal et al., 2010). Additionally, Walker et al. (2022) explored a diabetes support coach model in Federally Qualified Health Centers, where CHWs provided peer mentorship and support for diabetes care. This program successfully promoted self-care and improved health outcomes, underscoring CHWs' effectiveness in managing chronic diseases in underserved settings (Walker et al., 2022).

The Rural and Underserved Service Track (TRUST), as detailed by Klosko et al. (2023), incorporates CHWs into interprofessional care teams focused on rural health, fostering cultural competency and community engagement among providers. By including CHWs as integral team members, TRUST prepares healthcare professionals to address the social determinants of health that influence healthcare accessibility. For Beacon Health, CHWs can provide critical support in managing chronic conditions, improving preventive care access, and building trust within underserved communities (Klosko et al., 2023).

## Barriers to Access: The Role of Health Insurance

Limited access to health insurance poses a significant barrier to healthcare in rural areas. In Marshall and Elkhart Counties, where a large percentage of adults aged 19-64 are uninsured, financial barriers prevent many residents from seeking preventive or specialized care. Research by Renner et al. (2010) suggests that lack of insurance coverage directly impacts healthcare utilization, leading to higher reliance on emergency services and worsening health outcomes over time. Addressing these gaps through policy and support initiatives could improve healthcare access in underserved areas (Renner et al., 2010).

Furthermore, high rates of uninsured individuals in counties like Marshall and St. Joseph present a significant barrier to healthcare access, as many people cannot or do not receive necessary care. One way to address this issue is to train CHWs specifically in insurance navigation, equipping them to help individuals in both Indiana and Michigan understand and access available coverage options. Both states now offer Medicaid reimbursement for CHW services, which presents an opportunity to make CHWs a sustainable solution for expanding healthcare access.

In Michigan, this Medicaid reimbursement policy effective January 1, 2024, will fund CHW services for Medicaid-eligible individuals, provided that CHWs are registered with MI Medicaid and enrolled in the CHAMPS system. This policy enables Beacon Health to offset costs in Michigan, supporting efforts to help uninsured residents register for Medicaid and, consequently, access essential healthcare services. Indiana, similarly, has offered reimbursement for CHW services under the Indiana Health Coverage Programs (IHCP) since July 1, 2018. This policy covers CHW services across all IHCP programs, contingent on benefit package limitations, and recognizes the critical role CHWs play in reducing health disparities, improving provider communication, and enhancing health outcomes.

Leveraging these reimbursement models in both Michigan and Indiana allows Beacon Health to fund CHWs who are trained in insurance navigation and healthcare coordination. Expanding CHW roles across Beacon's service areas could help alleviate financial barriers for uninsured residents, enabling them to access preventive care, chronic disease management, and Medicaid enrollment support. By empowering CHWs to assist with insurance navigation and registration,

Beacon Health could improve healthcare access and equity across its service regions, directly addressing the needs of uninsured populations.

## Community Trust and Provider Retention

Building community trust and cultural competency is crucial in recruitment, retention, and establishing trust between providers and diverse patient populations. Programs that integrate training help providers build stronger relationships with patients, ultimately supporting long-term retention and satisfaction. The TRUST program, as highlighted by Klosko et al. (2023), emphasizes cultural sensitivity and patient-centered care, equipping providers with skills to address the specific healthcare needs of rural and diverse communities (Klosko et al., 2023).

Verhagen et al. (2014) demonstrate that CHWs who share cultural or linguistic backgrounds with their patients are more effective in promoting positive health behaviors, as patients are more likely to trust and engage with providers who understand their unique challenges. For Beacon Health, integrating cultural competency into provider training and onboarding could enhance retention and improve patient-provider relationships, making a positive impact on healthcare access and equity in diverse rural communities (Verhagen et al., 2014).

## Conclusion

Addressing healthcare provider shortages in rural counties requires a multifaceted strategy that combines targeted recruitment and retention initiatives, workforce development, integration of Community Health Workers, and measures to reduce health insurance barriers. While financial incentives like loan repayment programs can attract providers initially, long-term retention is more likely when providers feel supported both professionally and personally. Rural-focused training programs and CHWs can help fill critical gaps in primary care, mental health, and chronic disease management, making these communities more resilient in meeting healthcare needs.

Beacon Health may benefit from adopting a dual approach that not only supports provider recruitment but also deploys CHWs in high-need areas to extend care access. Additionally, advocating for expanded insurance coverage could reduce barriers, ensuring more consistent access to healthcare services. By prioritizing these strategies, Beacon Health can address healthcare access disparities and advance health equity across its rural and underserved regions.

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## Appendix B: Interview Guide

**Goal:** To identify current and future initiatives in the service area and within the Beacon Health System that is addressing Access to Providers.

### Introduction

Thank you for participating in this short interview. As you may know, Beacon Health System just completed its Community Health Needs Assessment (CHNA) and has started its Implementation Strategy Plan development.

The top community need that Beacon has decided to focus on addressing over the next few years is Access to Providers. We are speaking with you today to identify current and future initiatives that Beacon and/or its community partners might be taking to address access to providers in the community.

Providers is not limited to medical doctors/primary care providers. The CHNA research found the need for access to community health workers and peer support specialists, access to OB/GYNs, including childbirth at hospitals, the cultural competency of providers, and community mistrust of providers in their communities.

We are defining community in the questions below by each specific county your organization provide services for.

### Questions

1. Please tell me a little bit about yourself and your role at [Beacon or community partner]?
2. What does Access to Providers mean to you?
3. Are there any current initiatives that Beacon [or insert their organization name] is working on to address access to providers in the community? Can you please describe the initiatives and how they are impacting the community?
4. Are there other initiatives in the community that you are aware of that are addressing access to providers? What are they and who is implementing them?
5. What initiatives or programs would you like to see implemented to address access to providers in the community?

6. What differences do you see in access to providers in rural vs urban?
  
7. What barriers do you see in your community that has brought access to providers as a top need?
  
8. Is there anything else you think is important for us to know?

**Thank you for your time today!**



## Appendix C: CHNA Health Advisory Council and ISP Advisory Council

### CHNA Health Advisory Council Organizations

1st Source Bank	Northern IN Hispanic Health Coalition
Beacon Health System	Oaklawn Psychiatric Center
Bowen Health	Pivotal- Certified Community Behavioral Health Clinic
Branch-Hillsdale-St. Joseph Community Health Agency	REAL Services, Inc
City of Elkhart	Ribbon of Hope Cancer Support
Commission on Aging, St. Joseph County, MI	Saint Joseph Health System
Covered Bridge Healthcare	Self-Healing Communities of Greater Michiana
Crossroads United Way	South Bend Community Schools
Elkhart Community Schools	St. Joe County Public Library
Elkhart County Health Department	St. Joseph County, IN Department of Health
Elkhart Police Department	Transformation Ministries
Family Justice Center	United Health Services
HealthLinc	University of Notre Dame, Eck Institute for Global Health
Heart City Health	University of Notre Dame, Lucy Family Institute
Horizon Education Alliance	Wa-Nee Community Schools
La Casa de Amistad	
Maple City Health Care Center, Inc.	
Marshall County Health Department	
Mental Health Awareness of Michiana	

## ISP Advisory Council Members

NAME	TITLE
Amira Welch	VP of Patient Access Services
Cassy White, MPH	Manager of Community Health Outcomes
Cindy Hayes	VP of Beacon Medical Group
David Van Ryn, MD	Director of Medical Education
Donald Zimmer, MD, FACEP	Director of Medical Education and ER Physician for Memorial Hospital
Heather Wagner, MBA, MSN, RN	Director of Utilization and Case Management
Hope Bailey, DNP, RN	VP of Nursing for Three Rivers Health
Jason Marker, MD, MPA, FAAFP	Associate Director of Resident Program
John Bruinsma, MBA	Director of Care Coordination
Kari Diedrich-Fritz	Executive Director of Medical Specialties at Beacon Medical Group
Kimberly Green Reeves, MPA	Executive Director of Community Impact
Michael Nixon, JD	Director of Diversity, Equity and Inclusion
Scott Eshowsky, MD	Medical Information Officer
Susan Bettcher-Spangler	VP of Nursing and Operations at Community Hospital of Bremen
Susan King	Foundation President
Timothy McGovern	Executive Director of Beacon Medical Group

## Appendix D: Access to Providers Data Support



# 2024 CHNA Priority: Access to Providers

### Community Health Needs Assessments (CHNAs)

While CHNAs are IRS required, we view CHNAs as an **opportunity to engage** the communities they serve throughout our **four-county service area**, and better understand the health and social needs of its community members. We deployed a regional, highly interactive strategy for the 2024 CHNA. We used a new framework, MAPP 2.0, which helps to recognize and align resources across integrated sectors of the community by **emphasizing diverse and inclusive assessments** and planning activities to affect change.

### Secondary Data

The following table provides the HEALTH CARE PROVIDER RATIO (People per Provider) for 2023. The data shows that compared to the state and nation ratios, there is a shortage of primary care providers in Marshall County and St. Joseph County (MI). Despite being a more urban community, St. Joseph County (IN) also appears to have a shortage of providers. Additionally, the data suggests a mental health provider shortage in all counties except for Elkhart County. OBGYNs are nearly nonexistent in both Marshall County and St. Joseph County (MI). Overall, Elkhart County seems to be faring the best in terms of provider ratios  
Source: National Plan & Provider Enumeration System NPI, 2022.

HEALTH CARE PROVIDER RATIO (People per Provider) FOR 2023	Elkhart County	Marshall County	St. Joseph County, IN	St. Joseph County, MI	Indiana	Michigan	United States
Primary Care Physician	769:1	1,848:1	1,303:1	2,100:1	899:1	760:1	959:1
Primary Care Nurse Practitioner	721:1	1,491:1	1,866:1	2,537:1	935:1	1,603:1	1,251:1
Mental Health Provider	990:1	1,540:1	1,631:1	1,845:1	851:1	907:1	612:1
Pediatrician	1,347:1	11,406:1	1,913:1	4,931:1	962:1	780:1	860:1
OBGYN	2,673:1	22,838:1	6,041:1	10,072:1	3,200:1	2,953:1	3,762:1
Midwife and Doula	13,030:1	ND	34,738:1	15,108:1	18,474:1	10,068:1	12,073:1

Marshall and Elkhart County have a higher percentage of the adult population aged 19 to 64 without health insurance. This may be due to the limited work opportunities in each of the counties. Health insurance may be a barrier to some people when accessing health care services.

ADULT POPULATION AGED 19 TO 64 WITHOUT HEALTH INSURANCE	Elkhart County	Marshall County	St. Joseph County, IN	St. Joseph County, MI	Indiana	Michigan	United States
Uninsured Population	30,431	6,054	19,957	5,513	520,904	515,011	28,315,092
Uninsured Under Age 6 -	14.60%	18.00%	2.80%	8.30%	5.90%	2.80%	4.40%
Uninsured Age 6 to 18	14.70%	14.20%	6.10%	5.60%	6.30%	3.10%	5.70%
Uninsured Age 19 to 64 -	18.40%	16.20%	10.30%	13.00%	10.40%	7.40%	12.20%
Uninsured Over Age 65 -	1.70%	0.90%	0.40%	0.80%	0.50%	4.00%	0.80%

Research shows that access to health care contributes about 20% to a person's health outcomes. Many of the counties that Beacon Health serves have slightly higher percentage of CHRONIC DISEASE AMONG ADULTS AGED 18 AND OLDER (shown in the table below). Increase access to primary care and specialty care, such as cardiology and endocrinology, may help improve health outcomes for community residents.

PERCENTAGE OF CHRONIC DISEASE AMONG ADULTS AGED 18 AND OLDER	Elkhart County	Marshall County	St. Joseph County, IN	St. Joseph County, MI	United States
Current Asthma	10.50%	10.60%	10.50%	11.20%	9.70%
High Blood Pressure	31.40%	30.30%	32.00%	32.50%	29.60%
High Cholesterol	30.30%	30.80%	29.10%	31.60%	31.00%
Diagnosed Diabetes	10.90%	10.40%	11.10%	9.30%	9.90%
Obesity	38.20%	36.60%	36.10%	38.50%	33.00%
Stroke	3.10%	3.00%	2.90%	3.00%	2.80%
Depression	26.00%	26.50%	24.10%	25.25	19.80%

The data above was gathered from the United States Census Bureau 2018-2022 American Community Survey (ACS) Five-year Estimates, United States Centers for Disease Control and Prevention (CDC), CMS and the Indiana and Michigan Department of Health, among others.

## Community Surveys N = 1,383

In the past year, have there been one or more occasions when you needed medical care but chose NOT to get it?

	PERCENT OF RESPONDENTS				
	Elkhart n = 289	Marshall n = 170	St. Joseph (IN) n = 683	St. Joseph (MI) n = 241	Total n = 1383
Yes	25.00%	38.70%	27.80%	25.80%	28.30%
No	75.00%	61.30%	72.20%	74.20%	71.70%

If yes, what prevented you from accessing care when you needed it? (Check all that apply)

	PERCENT OF RESPONDENTS				
	Elkhart n = 72	Marshall n = 66	St. Joseph (IN) n = 190	St. Joseph (MI) n = 62	Total n = 391
Long wait times to see a provider	43.10%	46.20%	49.70%	32.30%	45.10%
No money / ability to pay	36.10%	26.20%	31.20%	51.60%	33.50%
Decrease of providers in my community	26.40%	33.80%	23.80%	21.00%	25.80%
Doctor's office does not accept my insurance	22.20%	23.10%	26.50%	19.40%	22.70%
No health insurance	27.80%	18.50%	15.90%	12.90%	18.10%
Provider did not listen to my needs	9.70%	15.40%	19.00%	32.30%	17.80%
Do not trust providers or staff	6.90%	9.20%	14.30%	27.40%	13.50%
No way to get to that service (Lack of transportation - car, bus, etc.)	11.10%	12.30%	11.10%	16.10%	12.30%
Providers or staff do not understand my culture	5.60%	10.80%	11.10%	4.80%	8.40%
Providers or staff are not knowledgeable about people with my sexual orientation or gender identification	6.90%	7.70%	9.50%	9.70%	8.20%
Concern about the impact on my immigration status	5.60%	4.60%	7.90%	4.80%	6.00%
My neurological or developmental conditions (such as ADHD, ADD, OCD, Autism, etc)	6.90%	4.60%	5.30%	8.10%	6.00%
Providers or staff did not speak my language	4.20%	4.60%	4.20%	6.50%	4.30%
COVID-19-related restrictions	4.20%	7.70%	3.20%	3.20%	4.10%

Survey respondents were asked the same question above about behavioral health care. Nearly one in four residents reported needing mental health or substance use services in the past 12 months and chose not to get it. Similar to medical care, the top reported reasons were "long wait times to see providers," "decrease of providers in my community," and "no money / ability to pay."

In the past year, have there been one or more occasions when you needed mental health or substance use services but chose NOT to get it?

	PERCENT OF RESPONDENTS				
	Elkhart n = 289	Marshall n = 170	St. Joseph (IN) n = 683	St. Joseph (MI) n = 241	Total n = 1383
Yes	20.60%	25.70%	25.90%	26.80%	24.20%
No	79.40%	74.30%	74.10%	73.20%	75.80%

On a scale of 1 (no more focus needed) to 5 (much more focus needed), which of the following community and health-related issues do you feel need more attention for improvement in your community?

	PERCENT OF RESPONDENTS				
	Elkhart n = 289	Marshall n = 170	St. Joseph (IN) n = 683	St. Joseph (MI) n = 241	Total n = 1383
Coordination of patient care between health service providers	49.20%	39.00%	47.90%	35.50%	45.20%
Case management (support and programs) for persons living with chronic diseases	45.50%	27.00%	44.60%	36.40%	41.10%
Primary care services (such as a family doctor or other provider of routine care)	31.70%	36.90%	41.80%	34.50%	38.40%

## Stakeholder Interviews (N = 35) & Focus Groups (N = 123)

"Sometimes [I] can find a primary care provider, but actually getting in can be several weeks to months wait."

"Patients can't find access to the care they need and often end up in the ER."

"Psychiatry is a desert, so many family MDs, OBGYNs, primary care providers do most medication management, but they're not required to have psychiatric training. So, these docs generally prescribe lower doses and are more conservative."

"[The] time it takes to see specialists and subspecialist on secondary side of things exacerbates the illness we currently have."

"You can't get connected to a specialist if you can't get the ED doctor to look at you. Some [providers] are missing bedside manners. They don't focus on your concerns."

"A lot of people are struggling finding a primary care provider, especially in the rural communities. There is some hesitancy with mid-level providers."

"We don't have community caregivers. We need more community health workers and peer support specialist."

"We hear stories - we heard one about a Haitian patient getting care - she came to our community pregnant, needed prenatal care. Providers didn't bother to learn what language she was speaking, no interpreter at her appointment. They didn't bother to learn she had Medicaid and billed her, so she was confused."

She showed up in the ER with complications because she was too scared to go to any future appointments."